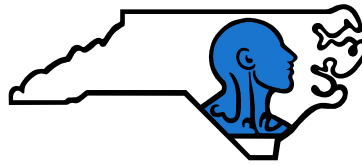


Pt. # \_\_\_\_\_

Dr. # \_\_\_\_\_

Loc. # \_\_\_\_\_



# Carolina Ear, Nose & Throat Head and Neck Surgery Center

## PATIENT REGISTRATION FORM

OCT/11

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

SSN#: \_\_\_\_\_ Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Ref. Phys.: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M F Marital Status: S M W D SEP

Race: \_\_\_\_\_ Language Spoken: \_\_\_\_\_

Ethnicity (circle one): Hispanic or Latino Not Hispanic or Latino Refused to Report

Home Phone: \_\_\_\_\_ Employer: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Does patient live at a Skilled Nursing Facility: Y N

Work Phone: \_\_\_\_\_ ext. \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Email Address: \_\_\_\_\_

### IN CASE OF AN EMERGENCY CONTACT:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

### BILLING AND INSURED INFORMATION (complete this section if the Insurance is in someone, other than the patient's name):

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

SSN: \_\_\_\_\_ Address (**if different**) \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

DOB: \_\_\_\_\_ Employer: \_\_\_\_\_ Wk#: \_\_\_\_\_

### PARENT INFORMATION (please complete if patient is a minor):

Name: \_\_\_\_\_ SS#: \_\_\_\_\_

DOB: \_\_\_\_\_ Employer: \_\_\_\_\_ Wk#: \_\_\_\_\_

I, being the patient or guardian do hereby request and authorize Carolina Ear, Nose & Throat Head and Neck Surgery Center, P.A. and their staff to perform necessary services to myself or my dependents, including, but not limited to, x-rays and administration of anesthetics which are deemed advisable by the physician. I also authorize Carolina Ear, Nose & Throat Head and Neck Surgery Center, P.A. to release any information required in the course of my examination to my physician and or insurance company. I understand that I am responsible for any amount not covered by insurance. I also understand that if my account has to be turned over to a collection agency I will be responsible for a \$100.00 non-refundable fee and will result in the termination of the physician/patient relationship.

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

*This information contained is **CONFIDENTIAL AND PRIVILEGED.***